

The Challenge of EHR Acceptance by Physicians

It's a matter of adapting to new thought processes and workflow.

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Physician practice adoption of electronic health record (EHR) systems is doing extremely well. This is especially true since the Health Information Technology for Economic and Clinical Health (HITECH) Act authorizing incentives for the Meaningful Use of EHRs took effect in 2009.

Prior to HITECH, industry estimates suggested that somewhere in the range of 10% to 20% of U.S. physicians had an EHR system. An Office of The National Coordinator for Health IT (ONCHIT) data brief in December 2014 reported that approximately 80% of eligible physicians were using or planning on using an EHR system.¹ That represents very impressive growth in the four-year period from 2009 to 2013. The data brief stated that 59% of eligible physicians have already adopted EHRs capable of achieving Meaningful Use. Another 12% have adopted other EHRs, though not necessarily capable of achieving Meaningful Use, and 10% have plans to adopt EHRs.

About 19% of all eligible physicians are not committed to moving

toward an EHR system. Of those, 3% plan to retire soon, 11% are uncertain what they are going to do, and 5% are willing to absorb penalties rather than invest in EHRs (Figure 1).

It should come as no surprise that the biggest driver (62%) for post-HITECH adoption has been financial incentives for the Meaningful Use of EHRs. To that end, over \$11

physician satisfaction and value from the system.

Are Physicians Satisfied with Their EHR System?

Several recent studies suggest that we have made progress with physician satisfaction, but still have a long way to go.

Accenture surveyed over 2,600 physicians in six countries, including 601 from the United States.² Key findings in the United States include:

- Seventy-nine percent of doctors in the survey believed they were more proficient using EHRs in their practices than they were two years ago.
- Use of routine EHR functions showed significant increase since 2012.
- Although most (64%) agreed that EHRs had a positive impact on reducing medical errors, the percentage had declined, from 72% in 2012. In addition, 12% thought that it negatively impacted medical errors, more than doubling from 5% in 2012.
- Seventy-one percent believed that healthcare IT decreased the amount of time spent with patients.
- Finally, 58% thought that their EHR was hard to use.

Interestingly, the United States was the only country in the study

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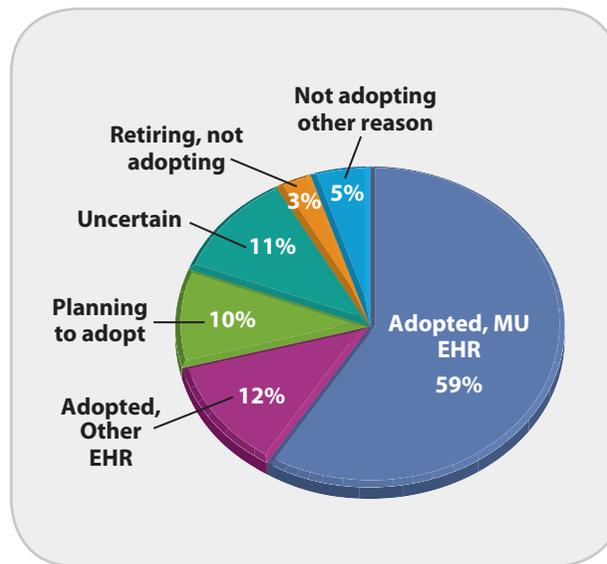


Figure 1: Physician adoption of electronic health record systems. (Data from reference 1.)

billion in federal EHR incentives has already been disbursed to physicians.

This represents a good first step toward realizing some of the many potential benefits patients, payers, health providers, and the national health system as a whole can attain. The next big step—some would say hurdle—is to attain high levels of



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with a majority of respondents making this statement.

An American Medical Association (AMA) press release in late 2014 called for a “design overhaul of electronic health records to improve usability” in reaction to their studies finding that discontent with EHRs is taking a significant toll on physicians.³ Among the most prominent concerns with EHRs mentioned in the 2013 research report were time-consuming data entry and user interfaces that do not match clinical workflow.⁴ These are not new concerns. As far back as the 1970s, when industry pioneers first started offering clinical systems targeted for physicians to use, it was recognized that achieving physician adoption and satisfaction presented difficult challenges. Although technology and methodologies have vastly improved, the core challenges stubbornly remain the same.

The Importance of Time

It can be argued that the two most valuable assets of a physician are medical knowledge and the time available to use that knowledge in helping patients. With time being such a scarce resource, it is logical

- Hire more staff to offset some of the additional work.

A variety of strategies have been attempted to mitigate time issues, with varying degrees of success. A few of the more common strategies are:

- Make systems more intuitive. This is the “holy grail” of physician

Thought Process Disruption

A colleague once told me, “Let me watch a physician treat a few patients, and I will be able to tell you what medical school he/she attended.” He went on to explain that each school had a unique way of teaching the diagnostic thought process to medical students. It included developing

Recognize there will be downstream savings/benefits by doing it electronically, such as fewer calls trying to decipher the scripts, and potential patient safety improvements.

system design. Whoever discovers how to do this on a large scale that works for the majority of physicians will have a tremendous market advantage.

However, what is intuitive for one doctor is probably not intuitive enough for another. There continue to be big differences among specialties, age groups, medical school attended, and the many other unique differences and preferences of each individual.

- Accept that some things will never be as fast using a computer

thought patterns for such things as the types of questions to ask a patient, the sequence in which to ask them, the routine and sequence for examining the patient, a decision tree approach to diagnose a problem, and an approach for documenting data in the patient record. These thought patterns get thoroughly embedded in the medical students’ psyche.

The thought process becomes habitual, governing physician behavior and work flow throughout their career. There is great inherent value in this. It establishes a clear comfort zone on how to do things; creates a mental checklist that provides consistency and thoroughness of care; and serves as an intuitive quality control mechanism. Perhaps most importantly, it frees up the mind to concentrate more on analytical and diagnostic thought.

In the paper world, providers follow their well-engrained and seamless process to collect disparate data from a variety of sources. They observe the patient, look for any physical signs or manifestations of problems, ask questions, review test results, and browse through thick patient charts that are meticulously organized to their liking. It is second nature for them to process and turn these data into information, followed by recording it into the patient record and orders.

Close study of provider processes suggests that they “are not accustomed to recording the pieces and

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With time being such a scarce resource, it is logical for physicians to focus on using their time efficiently.

for physicians to focus on using their time efficiently. Some argue that the three most important things to a physician considering using an EHR are “time, time, and time.” Any non-productive use of time has negative consequences. When faced with non-productive use of time due to an EHR, physicians encounter a set of difficult options to deal with the time inefficiencies. A few of these choices are:

- Work more hours with no corresponding increase in income;
- See fewer patients and reduce income;
- Spend less time with each patient; and

as doing it manually (e.g., writing a prescription). Also recognize there will be downstream savings/benefits by doing it electronically, such as fewer calls trying to decipher the scripts, and potential patient safety improvements. This requires influencing physicians to see the “whole picture” rather than focusing only on the frustrating extra seconds or minutes spent entering information on each patient.

- Improve overall “usability” as recommended by the AMA.

- Pay more attention to workflow in designing and implementing systems. More on this later.

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parts of the puzzle, only the final picture.”⁵ EHRs often require providers to record data in a pre-defined sequence, organize notes and orders in a manner very different from what they are accustomed to, and use structured coding/language that is not what they have been using. This can be extremely disruptive, causing angst and a sense of inefficiency, and literally slowing them down as they rethink their way through new processes. It is no wonder that many physicians have already used two or three different EHRs, with only modest improvement from one to the next.

Change is hard. Relearning to do something you have done extremely well, in a new and different manner, is even harder.

The challenge is not to avoid change—because change is unavoidable. Instead, the challenge becomes how to create reasonable expectations and minimize the level of disruption. Dealing with the thought process disruption of an EHR is a subtle, yet important, consideration you will have to make when acquiring and implementing an EHR system. Here are some practical tips how to approach this with your medical staff:

- Create awareness of the potential problem of thought disruption. In my experience helping scores of physician practices with EHRs, no one has ever introduced the issue of thought disruption. However, after starting a conversation with them about it, most quickly relate to it, often saying they are experiencing this phenomenon.

- Create the expectation that while today’s EHRs are making good progress in system usability and adaptability to workflow, the problem can be mitigated, but not eliminated.

- Mitigation will require active physician involvement.

- Create reasonable expectations of what the overall inefficiencies of the new system may be, especially how it may take longer to complete all the patient documentation. This

will be most acute when first using the system.

- Conversely, create reasonable expectations of what “downstream benefits” they might achieve to offset some of the inefficiencies. There are real time savings that are only apparent when measuring total time spent in a workday, as opposed to time spent documenting the patient visit. Common examples of this include fewer calls seeking clarifica-

tion, implementation, and fine tuning of the system.

- Develop reasonable expectations. Answer questions such as:

- Why do you want an EHR system? If the only reason is to get Meaningful Use incentives or avoid penalties, you will probably not be happy with the results and may want to compute whether it makes more economic sense to *not* get an EHR system.

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tion of medication orders, less time spent searching for the patient chart, and ease of access to the records from any location with a computer connection.

The Importance of Workflow

Another important consideration to make in acquiring and implementing an EHR system is how to manage the workflow and process changes. Physician workflow will change. Failure to recognize this results in much unnecessary frustration and inefficiency.

The first and foremost consideration in addressing workflow is to establish a thoughtful and objective process for selecting an EHR system. If nobody in your organization has experience in doing this, consider using outside assistance from industry consultants or Regional Extension

Centers (RECs) in your area. Note that RECs are federally subsidized organizations chartered to serve as a resource to assist providers in EHR implementation and healthcare IT needs. A few highlights to keep in mind are:

- Recognize that acquiring and implementing an EHR system is not just a technology or IT project. It requires active and thoughtful engagement of those who are going to be the most impacted by it—including physicians. They need to be involved throughout the planning, vendor se-

- What are the most important things you want out of a system? Skip the buzzwords, and define what is really important to the physicians and practice.

- What types of benefits do you expect to achieve? Set reasonable goals for both quantifiable and intangible benefits.

- How will you deal with temporary or permanent inefficiencies medical staff will need to endure, such as taking more time to treat and document care for each patient visit?

- Include adaptability of the system to the physician workflow, and intuitiveness/ease of use as key selection criteria. These can be very ambiguous and mean different things to different people, so a good cross section of opinion and involvement is critical.

- Adaptability to physician workflow means how well (and easily) the system can be tailored to the workflows of the medical staff that will be using it, thus minimizing the amount of disruption it will cause. Use caution in dealing with this flexibility. Allowing each provider to do things his or her own way will create chaos in the patient record and management of the practice.

- Intuitiveness and ease of use are simple concepts that just about all of your providers will grasp. However, a system that appears intuitive for one

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person may create the opposite impression for another. Products continue to get better, but no one has found the magic bullet to “make it as easy to use as an iPhone” yet. The best you can hope for today is a general consensus on which vendor or product does it the best for your providers.

- Assess your current processes and workflows and determine how they should be modified when you switch to an EHR system. Find some common ground among the medical staff for the new workflow. Establish guidelines on what data and process standards are expected to be followed by all, and to what degree you will permit tailoring.

Conclusion

It has been a bumpy ride for many providers as they adopt EHRs. Products will continue to get better, but will still necessitate changes in physician workflow and distribution of how and where their time is spent. It is critical for vendors and physician practices to understand the impact EHRs will have on disrupting the physician thought process and workflow. A big part of dealing with that disruption is to have a good change management process established that creates reasonable expectations, anticipates changes, and sets a strong foundation for success. **PM**

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